



# ERA (835) Enrollment Form

Complete form and email to: [EDISpecialist@iehp.org](mailto:EDISpecialist@iehp.org)

Type of Electronic Submission  835/ERA  Web Portal  Both

## Provider Information

Provider Name \_\_\_\_\_ Doing Business As (DBA, if Applicable) \_\_\_\_\_

Provider Physical Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## Provider Identifiers Information

Provider Federal Tax Identification Number (TIN) \_\_\_\_\_ or Employer Identification Number (EIN) \_\_\_\_\_

National Provider Identifier (NPI) \_\_\_\_\_  
(Group NPI, if applicable)

Other Identifiers \_\_\_\_\_

Trading Partner Identifier (ID) \_\_\_\_\_

## Provider Contact Information

Provider Contact Name \_\_\_\_\_ Title \_\_\_\_\_

Telephone Number with Extension \_\_\_\_\_ Email Address \_\_\_\_\_ Fax Number \_\_\_\_\_

Preference for Aggregation of Remittance Data (e.g. Account Number Linkage to Provider Identifier)  
(Must match EFT Preference)

Provider Tax Identification Number \_\_\_\_\_

National Provider Identifier \_\_\_\_\_

Method of 835 Retrieval:  From health plan  Download from health plan website  From clearinghouse

## Electronic Remittance Advice Clearinghouse Information

Clearinghouse Name \_\_\_\_\_

Telephone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Reason for Submission

New Enrollment       Change Enrollment       Cancel Enrollment

Authorized Signature

\_\_\_\_\_  
Electronic/Written Signature of Person Submitting Enrollment

\_\_\_\_\_  
Printed Title of Person Submitting Enrollment

\_\_\_\_\_  
Submission Date

\_\_\_\_\_  
Requested ERA Effective Date

**Consent to Access Remittance Advice (RA) via IEHP Provider Website Only**

IEHP's goal is provide our Trading Partners with a convenient method of receiving the remittance advice (RA). We are requesting your consent to discontinue mailing paper RAs. After your authorization is received, you will obtain access to your RA through the IEHP secure website, [www.iehp.org](http://www.iehp.org). To view your RA on the secure provider website, you must have access to the internet as well as the current version of Adobe Acrobat Reader. Our Trading Partner's security is important. Only contracted partners with upgraded web security will be able to access RAs online. If your security has not been upgraded, you may do so by following the directions on our website or calling the IEHP Provider Relations Team at (909) 890-2054.

\_\_\_\_\_  
Provider Name

\_\_\_\_\_  
Tax Identification Number (TIN)

I \_\_\_\_\_ (print name and title) authorize IEHP to discontinue mailing the paper Remittance Advice (RA) and agree to access IEHP Claims RAs online only.

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

## Instructions for completing the ERA Enrollment form

Please type or print legibly.

Use only black ink or blue ink to complete paper form.

Online form can be accessed at [www.iehp.org](http://www.iehp.org)

Please allow 4 weeks for enrollment process which includes pre-note verification. If after 4 weeks you do not start receiving ERA files, you may contact the EDI Specialist Team at 909.890.2025 or send an email to [EDISpecialist@IEHP.org](mailto:EDISpecialist@IEHP.org).

**For questions about the paper or electronic enrollment process, contact the EDI Specialist Team at 909.890.2025 or send an email to [EDISpecialist@IEHP.org](mailto:EDISpecialist@IEHP.org)**

### Provider Information- Please fill out completely

**Provider Name** – Complete legal name of institution, corporate entity, practice, individual name or DBA, if applicable

**Provider Physical Address** – The number and street where a person or organization can be found

**City** – City associated with provider address field

**State** – ISO 3166-2 two character code associated with the state

**Zip Code/Postal Code** – System of postal-zone codes

### Provider Identifiers

**Provider Federal Tax Identification Number (TIN) or Employer Identification Number (EIN)** – A TIN or EIN is used to identify business entity.

**National Provider Identifier (NPI)** – A Health Insurance Portability and Accountability Act (HIPAA) Administrative Simplification Standard. The NPI is a unique identification number for covered healthcare providers. Covered healthcare providers and all health plans and healthcare clearinghouses must use the NPIs in the administrative and financial transactions adopted under HIPAA. The NPI is a 10-position, intelligence-free numeric identifier (10-digit number). This means that the numbers do not carry other information about healthcare providers, such as the state in which they live or their medical specialty. The NPI must be used in lieu of legacy provider identifiers in the HIPAA standards transactions.

### Other Identifiers

**Trading Partner ID** – The provider's submitter ID assigned by the health plan or the provider's clearinghouse or vendor

### Provider Contact Information

**Provider Contact Name** – Name of contact in provider office for handling ERA issues

**Provider Contact Title** – Title of the contact for handling ERA issues

**Provider Contact Telephone Number** – Telephone number of provider contact with extension, if applicable

**Provider Email Address** – An electronic mail address at which the health plan might contact the provider

**Provider Fax Number** – A number at which the provider can receive facsimiles

**Preference for Aggregation of Remittance Data (e.g., Account Number Linkage to Provider Identifier):** Provider preference for grouping (bulking) claim payments – must match preference for EFT payment

Must fill out one of the two options below

**Provider's Tax Identification Number (TIN)**

**National Provider Identifier (NPI)**

**Method of Retrieval** – Method in which provider will receive the ERA from the health plan

### Clearinghouse Information

**Clearinghouse Name** – Official Name of the provider's clearinghouse

**Telephone Number** – Telephone Number of contact

**Email Address** – An electronic mail at which the health plan might contact the provider's clearinghouse

**Reason for Submission** – Must select from below

**New Enrollment**

**Change Enrollment**

**Cancel Enrollment**

## Instructions for completing the *ERA Enrollment form*

### Authorized Signature

The signature of an individual authorized by the provider or its agent to initiate, modify or terminate an enrollment. May be used with electronic and paper-based manual enrollment

**Electronic/Written Signature of Person Submitting Enrollment** – A (electronic or cursive) rendering of a name unique to a particular person used as confirmation of authorization and identity

**Printed Title of Person Submitting Enrollment** – The printed title of the person signing the form; may be used with electronic or paper-based manual enrollment

**Submission Date** – The date on which the enrollment form is submitted

**Requested ERA Effective Date** – Date the provider wishes to begin ERA; per Phase III CORE Health Care Claim Payment/Advise (835) Infrastructure Rule Version 3.0.0: there may be a dual delivery period depending on whether the entity has such an agreement with its trading partner.

Email the completed form to: [EDISpecialist@IEHP.org](mailto:EDISpecialist@IEHP.org)

For questions about this form, please send an email to the EDI Unit at: [EDISpecialist@IEHP.org](mailto:EDISpecialist@IEHP.org)

### Researching Missing/Late Files

ERA files that have not been received after 4 business days of the corresponding EFT file can be researched by sending an email to the EDI Specialist Team at [EDISpecialist@IEHP.org](mailto:EDISpecialist@IEHP.org)